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SUMMARY OF COURT OF INQUIRY INTO THE DEATH OF Q994810 MAJOR N.J. MCNUTT, RNZIR

Introduction

1. Attached is a summary of the Court of Inquiry (COI) into the death of Q994810 Major N.J. McNutt, RNZIR. It details in narrative form, the events leading up to and subsequent to his death and summarising the court's findings, conclusions and recommendations. It is my intention that CO 1 NZSAS Gp present this summary to the family, in person, ahead of its release to the media.

J. MATEPARAE
Brigadier
Land Component Commander

Enclosure:

1. Summary of the Court of Inquiry into the death of Maj N.J. McNutt, RNZIR at Udairi Range, Kuwait on 12 March 2001

~~STAFF IN CONFIDENCE~~

Summary of the Court of Inquiry
Into the death of Maj N.J. McNutt, RNZIR
At Udairi Range, Kuwait on 12 March 2001

Background

1. A Court of Inquiry was assembled by order of Brigadier J Mateparae, ONZM, then Land Commander, on 15 Mar 01, to examine the circumstances surrounding the death of Maj Neil John McNutt, RNZIR, in a training accident in Kuwait three days earlier.

Conduct of the Court of Inquiry

2. The Court of Inquiry, comprising s. 9(2)(a) RNZIR and s. 9(2)(a) RNZIR did not have the authority to compel the attendance of foreign witnesses who were involved in the incident, and was therefore unable to interview any direct witnesses who were not members of the NZDF. Accordingly, the only witness interviewed was s. 9(2)(a) who acted as the NZDF representative on the US Central Command (USCENTCOM) Investigation Board.

3. During his evidence, s. 9(2)(a) tabled a copy of the Executive Summary of the Investigation Board report, which included the findings of the USCENTCOM Board. Also included were other exhibits such as medical documentation and the post-mortem examination. Although it would have been preferable for direct evidence to be obtained, under the circumstances the approach adopted by the Court of Inquiry was appropriate and complied with legal requirements.

4. The incident itself occurred at approximately 1900 hours local time on 12 March 2001, on the Udairi Range, Northern Kuwait. Maj McNutt was part of a team of military personnel from the US and Kuwait, observing a Close Air Support (CAS) Exercise from a purpose built Observation Post, OP 10. The exercise consisted of flights of aircraft from the US Aircraft Carrier, Harry S. Truman, performing attacks on ground targets on the range, using live ordnance. The incident occurred when three 500 pound bombs were dropped on OP 10, killing six personnel, including Maj McNutt, and injuring 11 others.

Methodology of the Board of Inquiry

5. The USCENTCOM Board consisted of a team of senior US Military officers headed by s. 9(2)(a) USMC, with participation from s. 9(2)(a) representing New Zealand, and s. 9(2)(a) from Kuwait. It conducted its inquiry in five phases:

a. collection of data and evidence,

b. analysis of data and evidence,

c. preparation of statement of facts

d. analysis of statement of facts and

e. development of opinions.

6. As part of the collection and analysis of the data and evidence, the Board visited the site of the incident and the aircraft carrier where they examined the aircraft involved. All aspects of the aircraft's equipment, operation and maintenance were reviewed. This review included the "black box" flight data recorder, cockpit voice tapes, gun camera video tapes from the incident aircraft and other aircraft in the skies at the time, as well as radar tracking data from both the Kuwaiti Ground Radar and the Airborne Warning and Control System (AWACS) aircraft. This enabled the Board to assemble an accurate, composite picture of the location, altitude, speed and compass heading of each aircraft throughout the incident. They were able to obtain a transcript of cockpit voice transmissions, as well as accurately establish the time of each event.

7. In addition the Board interviewed witnesses, including survivors of the bombing, ground personnel who participated in or observed the CAS Exercise, and aircrew actively involved in the mission. It was noted that the incident pilot and the pilot of the Forward Air Controller (Airborne) (FAC(A)) aircraft engaged in the mission, declined to be interviewed by the Board after consulting with legal counsel. The Board was able to draw on the technical expertise of outside agencies such as the Defense Computer Forensics Laboratory, and the Aircraft and Weapons Divisions of the Naval Air Warfare Centre.

Medical, Training, Equipment and Procedural Matters

8. In reviewing the training and medical history of the incident pilot and the aircrew of the other aircraft, the Board concluded that there were no medical or psychological factors present at the time of the incident. There was no indication of illicit substance abuse, self-medication or other bio-medical issues that should have prevented them from flying.

9. All aircrew involved were highly regarded as competent, fit and professional crew who were all qualified and "current" on the aircraft, equipment types and the mission profiles being flown. The incident pilot had amassed 1194 hours on the F/A 18 Hornet out of a total of 3341 hours flown at the time of the accident. He was considered to be a mature, experienced pilot who enjoyed the confidence of his superior officers. The pilot of the FAC (A) aircraft had amassed a total of 1206 hours flying time in his naval career and similarly enjoyed the confidence of his superiors.

10. The Board was satisfied that the aircraft and its weapon systems functioned correctly throughout the mission and did not experience any mechanical or system malfunction that would have contributed to the incident. Likewise, ancillary equipment such as Night Vision Goggles (NVG), the Forward Looking Infra Red (FLIR) pod, Head - Up Display and Target Designator Control all functioned as designed.

11. The Ground Forward Air Controller (GFAC) was fully qualified and current to conduct ground attack missions in accordance with the appropriate military instructions pertaining to his actual duties and role on the day. The GFAC was considered a highly experienced and proficient operator who was familiar with both the duties of his appointment and the specific idiosyncrasies of the Udairi Range. He had the correct equipment for his mission and had correctly marked the OP for both day and night operations.

The Udairi Range

12. The Udairi Range is a multi-purpose range designed to support a number of weapon systems, including CAS live-fire training. It is located on the desert floor in Northwest Kuwait. It has limited contours and terrain features. The impact area is not fenced and is inhabited at various times by Bedouin.

13. Since August 2000, and prior to the incident in which Maj McNutt was killed, there had been 6(b)(i) documented incidents at the Udairi Range. Range Control measures implemented as a result of those incidents included:

a. Increased safety distances around Bedouin camps,

b. More visible, vehicle size targets were sited in the range, and

c. A tower was constructed on OP 10 and the rooftop was painted white with a red cross.

14. It is considered that despite the previously documented incidents and attempts to improve conditions, OPs and targets remained difficult for pilots to see by day or night.

The Incident

15. The incident took place at night. The weather at the Udairi Range was described as scattered cloud with visibility out to 10 nautical miles. The target set, as seen from the air, was a cratered blackened out area with indiscernible vehicles vice a defined target array. The OP was on the ridge two km south of the target area and marked by a white strobe light. In and around the Udairi Range there were multiple light sources including manned OPs, Bedouin campsites (within 2-4 km), and other vehicles.

16. The GFAC personnel arrived at OP 10 just after 0800 hours that morning. During the day portion of the exercise, the GFAC directed a flight of fighters to return to base because they could not positively identify the friendly and target locations. The GFACs had marked the friendly location with smoke, two high visibility panels and an orange parachute canopy panel. For night operations, the GFAC marked the OP with a visible white strobe light, an Infra Red (IR) strobe light, and a circular pattern of chemical sticks.

17. One of the observers at OP 10 volunteered to operate the IR pointer that was used to illuminate the target for the incident Pilot.

18. Upon arrival at the Range, at 1735 hours local time and just prior to sunset, the FAC (A) flew over the target area, without infra red or Night Vision Goggles at 1000 feet Above Ground Level (AGL).

19. The FAC (A) and GFAC agreed that they would share responsibility for control of the in-coming strike aircraft. The GFAC would observe and control the attack of the fighters and retain "Final Clearance Authority" for bomb release. The FAC (A), flying in another aircraft, was responsible for aircraft check-in and target area orientation, to include talk-on of the aircraft to the OP and the target.

20. The incident aircraft was identified as Lion 71, one of a flight of three F/A 18 Hornet aircraft identified as Lion flight, and was preceded by Sniper flight, a flight of two F/A 18 aircraft.

21. After arrival at Udairi Range, neither Sniper flight nor Lion flight performed clearing passes, nor did the FAC (A) or GFAC request they do so. The GFAC stated that he did not think these aircraft were required to perform a clearing pass because the FAC (A) had conducted one earlier during the day to positively identify the OP and target and verify the absence of Bedouin and livestock. Sniper acknowledged all restrictions on run-in, the no fire area around the OP, and the requirement for a "Target in sight, friendlies in sight" prior to being given "Cleared Hot."

22. Sniper acknowledged both the friendly and target locations to the FAC (A), then described the ridge, the Infra Red strobe light on OP 10, and the craters in the target area. The Sniper flight received 18 separate descriptive calls from the GFAC and FAC (A) on target and friendly positions and expressed difficulty seeing both the target and OP 10 prior to first weapon release.

23. The non-standard radio call by the FAC (A) of "Good nose position," made on all Sniper flight attack runs preceded all GFAC "Cleared Hot" calls. The GFAC stated that the "Good nose position" calls gave him a misleading perception of the inbound aircraft's position, but he did not base his "Cleared Hot" calls on them. All Sniper attacks occurred after a "Cleared Hot" by the GFAC, with all weapons impacting the target area.

24. Like Sniper, the Lion 71 (incident) pilot acknowledged all restrictions on run-in, the no fire area around the OP, and the requirement to call "Target in sight, Friendlies (OP) in sight" prior to being given "Cleared Hot." Lion 71 identified the target and OP during his pass over the Udairi Range prior to his target run, however, he never identified them both at the same time. While he acknowledged both the OP and target location talk-on with "Copy," he never described the ridge or strobe on OP10 and the darkened areas of the target area.

25. Lion 71 received 14 descriptive calls from the FAC (A) and GFAC prior to turning inbound on the attack run, and continued to communicate descriptions that caused both observers to believe he had correctly identified the target and OP. He then overflew the OP and the target and proceeded outbound. After he turned inbound, the aircraft was pointed at the OP and requested that the target be illuminated. The GFAC took his eyes off Lion 71 and turned to ensure that the observer was illuminating the correct target. When he turned back to reacquire Lion 71, he saw three aircraft.

26. The GFAC asked if "Lion 71" was inbound and received the reply, "Inbound." Lion 71 never transmitted "Target in Sight, Friendlies in sight" during his attack run. The FAC (A) continued using non-standard CAS communications, transmitting "Good Nose Position," which the incident pilot and GFAC received.

27. The incident pilot released weapons before receiving "Cleared Hot" from the GFAC, the aircraft recording two firing pulses (bomb release "pickle button" depressions). One pulse before the "Cleared Hot," which caused weapons release, and one pulse after the "Cleared Hot" call (post weapon release).

28. Immediately after weapons release, the GFAC called "Cleared Hot on Sparkle." "Sparkle" was cut off by Lion 71 calling "Cleared Hot". At this point, the GFAC realised that the incident pilot had targeted the OP and called "Abort, Abort, Abort." However he was too late, as Lion 71 had already released his weapons. Three Mk 82 500-pound bombs impacted and detonated within 50 m of OP 10, killing five service members including Maj McNutt. Six U.S. and six Kuwaiti service members were also injured. One US service member subsequently died en route to hospital. At the time of the incident, 10 U.S., six Kuwaiti, and one New Zealand (Maj McNutt) service members were at OP 10.

Post Incident Actions

29. All flights returned to USS Harry S. Truman, landing uneventfully. The FAC (A) also landed uneventfully after acting as the on-scene mission commander for the Medevac effort.

30. Immediately following the explosions, a USAF service member at the scene requested Medevac support to OP 10. The US survivors provided self-aid/buddy aid to the victims. A Special Forces team with one medic was coincidentally enroute to OP 10 and arrived shortly after the incident, where they continued to provide aid until after outside assistance arrived.

31. At 1915 hours local time, Range Control notified local military medical agencies, which then implemented casualty evacuation and treatment procedures as well as notifying the Kuwaiti Ministry of Defence.

32. On 15 Mar 01, the six deceased service members had autopsies performed at Landstuhl Regional Medical Centre in Germany. Cause of death was determined for Maj McNutt as being due to a single shrapnel injury to the head. Arrangements were then made to have the deceased repatriated to their respective countries.

Conclusions

33. On 12 March 2001, a US Navy F/A-18 from the USS Harry S Truman dropped three, 500-pound bombs on OP 10 at Udairi Range, Kuwait, during a CAS exercise. Five US military personnel and one New Zealand Army officer died. Five other US military personnel and six members of the Kuwait Army were injured.

34. The cause of the accident was pilot error. The Board's finding was underlined by the fact that the Sniper flight, having similar difficulty in distinguishing the target and the OP to that later experienced by Lion 71, engaged in a lengthy "talk on" procedure and successfully dropped his bombs in the impact area. Lion 71, by contrast, adopted a more abbreviated "talk on". As a result, he improperly identified and designated OP 10 as the target, releasing his weapons prior to receiving clearance to do so.

35. The identification of OP 10 as the target is considered to have been a combination of several factors, including:

a. Non-standard communication between the incident pilot, GFAC and FAC (A);

b. Other light sources in the area, including a Bedouin camp 2-4 km west to south west of the OP;

c. No simultaneous identification of the target and OP; and

d. Misidentification of the IR illumination source on OP 10 as the target.

36. Additional contributory factors were:

a. The FAC (A) pilot's actions. His misleading assessments of the incident aircraft's heading relative to the target during the attack run gave both of the GFAC and the incident pilot a false sense that the aircraft was correctly aligned with the target.

b. The GFAC's actions. He accepted non-standard terminology (inbound, nose position, etc). The request by Lion 71 to illuminate the target caused the GFAC to turn his attention to an observer using the IR pointer to ensure the correct target was marked. This diverted the GFAC away from maintaining visual on the incident aircraft during the last phase of the attack run thus reducing the time for an "Abort" call.

c. The conditions at the Udairi Range. Both the OPs and targets were reported as being very difficult to see both by day and night.

37. The U.S. and Kuwaiti medical response was effective and well co-ordinated, however it could not have prevented the deaths of six service members. They died as the result of injuries sustained from the detonation of three 500-pound bombs within 50 meters of OP 10, Udairi Range.

38. Three sets of Kevlar helmets and vests were located at OP10, for the use of Explosive Ordnance Disposal (EOD) team personnel. Although issued, there was no mandated requirement for personnel to wear these items during CAS Exercises while at the OP. The Kevlar helmet and vest are designed to protect the wearer from limited small arms and fragmentation injuries. Arguably, wearing these may have lessened the extent of injuries and may have provided increased survivability.

39. It was noted that securing the site and evacuation of the deceased service members was conducted in a solemn and dignified manner.

US Recommendations

40. The report concluded by making a number of recommendations as detailed below:

a. That appropriate administrative or disciplinary action be taken against the incident Pilot, the Forward Air Controller (Airborne) Pilot, and the Ground Forward Air Controller.

b. That the planning and execution of joint and combined live fire events on Udairi Range should be improved.

c. That safety on Udairi Range must be improved, including the wearing of personal protective equipment during live fire events.

d. That US Medical team deployments continue in order to foster medical co-operation and support.

e. That appropriate recognition should be considered for certain personnel for their post-incident actions.

NZ Findings

41. The NZDF Court of Inquiry echoed these findings, in that the accident was caused by human error. It noted that:

a. Administrative or Disciplinary action as appropriate was recommended against the incident pilot, FAC (A) and GFAC;

b. Standardisation, planning co-ordination and safety needed to be improved on the Udairi Range; and

c. The USCENTCOM Board had commended certain individuals for their post-incident actions. This included personnel who had provided medical treatment and certain other support given to those involved in the incident.

42. The Court of Inquiry went on to recommend that NZDF should maintain its current safety regulations and procedures for FAC training in NZ and abroad.